Value-Based Insurance Design (VBID) Task Force

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September 19, 2014

Overview

- Establishment and Charge of Task Force
- Task Force Members
- Review VBID definition
- Review of Public Comment
- Next Steps

Task Force Establishment

- 2012: Concerns raised about increased enrollment in high-deductible health plans and their effect on patient outcomes
- March 2013: Council discussed VBID strategy
  - University of Michigan VBID Center hired as consultant to provide recommendations on promoting VBID in Maryland
- October 2013: Consultants submitted final report; Council passed motion to establish Task Force
- December 2013: Council passed motion to accept charter

Task Force Charge

- "Develop and recommend specific policy options and clinical areas and services for VBID in the Maryland Health Benefits Exchange and self-insured employer insurance market."
- "The basic premise of VBID is to align patients' out-of-pocket costs, such as copays and premiums, with the value of health services."
- "By reducing barriers to high-value treatments through lower costs to patients – "carrots" -- and discouraging low-value treatments through higher costs to patients – "sticks"-- plans can achieve improved health outcomes at any level of health care expenditure."

Members and Staff

Members

- James Chesley, MD
- Larry Gross
- Nicolette Highsmith Vernick, MPA
- Edward Koza, MD
- Lindsay H. Lucas, MBA
- Roger Merrill, MD
- Lisa Ogorzalek, JD, MHA
- Anne Timmons, CEBP
- Brenda Wilson

DHMH Staff

- Laura Herrera, MD, MPH
- Mona Gahunia, OD
- Donald Shell, MD, MPH
- Sara Cherico-Hsii, MPH

VBID Definition: Opening Statement

- VBID plans are built on the principles of engaging your members in their health and well-being, and designing a benefit plan that
  1. Promotes wellness by emphasizing primary/preventive care;
  2. Lowers or removes financial barriers to essential, high-value clinical services; and
  3. Discourages the use of low-value health services and providers.
- VBID plans clearly communicate with their members and provide tools to allow members to use their health plan more effectively and efficiently.
- VBID benefits are structured to offer rewards and incentives to members for being well and using the health care system efficiently. They align patients' out-of-pocket costs, such as copayments, with the value of services.

Original VBID Definition

- In Maryland, plans must contain the following elements in order to be considered a baseline VBID plan:
  - At least three incentives to use high-value services. A high-value service is one that is accepted in the peer-reviewed literature as providing considerable clinical benefit, relative to the cost;
  - At least two incentives to promote wellness and health among members. Incentives may include promoting disease management programs, health assessments, biometric screenings, tobacco cessation, weight management programs, and other health behavior programs; and
  - Targeting incentives and interventions to specific patient groups (e.g. those with chronic disease(s)).
- Recognizing that many VBID plans evolve over time and slowly incorporate different incentives and disincentives, plans that contain the following element will receive a higher rating or recognition in the Exchange:
  - At least one incentive to discourage low-value or unproven services. A low-value or unproven service is one that does not provide substantial health benefit relative to the cost.

Revised VBID Definition

- A VBID plan would require the following elements:
- Incentives
  - Incentives to use high-value services for at least three medical conditions. A high-value service is one that provides considerable clinical benefit, relative to the cost;
  - At least three health and wellness incentives available to all plan members. Incentives may include disease management programs, health assessments, biometric screenings, tobacco cessation, weight management programs, and other health behavior programs (e.g. Million Hearts); and
- Disincentives
  - Disincentives to discourage low-value or unproven services for at least three medical conditions. A low-value or unproven service is one that does not provide substantial health benefit relative to the cost.
- All incentives and disincentives must be evidenced-based, supported by professional organizations, and affect a meaningful number of members when implemented.
- The mandated preventative benefits covered under the Affordable Care Act will not be considered high-value services.

Review of Public Comment

- Posted on August 11, 2014 to the DHMH main webpage and emailed to relevant stakeholders
- Comments due by September 12, 2014
- Received 10 comments:
  - 5 from health plans and health systems
  - 2 from consumer groups
  - 2 from lobbying firm and consulting group
  - 1 from a large employer

Review of Public Comment

- Minor changes proposed in the comments include:
  - Do not limit professional support to Choosing Wisely
  - Change the number of health and wellness incentives back to two
  - Include examples of tools to include cost-sharing, copayments and deductible exemptions
  - Better define incentive and disincentive; clearly define an incentive for use of high-value service as “reduced or no cost sharing”

Review of Public Comment

- Major changes proposed in the comments include:
  - Not requiring a disincentive to be designated as a VBID plan
  - Incentivize services over medical conditions
  - Use available evidence to determine low and high value services
  - Remove the health and wellness component from the definition
  - Require patients to be active participants in their care
  - Require financial incentives for consumers to choose high-quality and cost-effective physicians

Review of Public Comment

- Process improvements proposed in the comments include:
  - Invite consumer and safety-net stakeholders to participate on the VBID TF
  - Develop a list serve for those interested in receiving information
  - Educate members on their health and health plans, focusing on quality and cost-effectiveness
  - Education providers on VBID
  - Clearly define the research that went into the creation of the definition

Review of Public Comment

- Other comments include:
  - Incentivize consumers to choose high quality plans/providers
  - Physician-patient relationship is an essential factor in determining an appropriate care plan
  - Clinical procedures and services are constantly evolving as new standards of care are established and practice parameters are development
  - What government entity would be responsible for overseeing VBID implementation and certification?
- Additional research questions:
  - Query health plans to determine which VBID elements are currently available in Maryland
  - Better understand what incentives actually work to change consumer and provider behavior

Next Steps

Discussion